		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033498

Facility Name: Coventry Village

Address: 612 W. St. Mary's Road (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: 815-626-9020 **Fax #** 815-626-6434

IDPA ID Number: 36-3549632-001

Date of Initial License for Current Owners: 3/27/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Scott Farnam **Telephone Number:** 847-272-9686

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Harris F. Webber
(Title) General Partner

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	124	Skilled (SNF)	124	45,260	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	6	Sheltered Care (SC)	6	2,190	5
6	0	ICF/DD 16 or Less	0	0	6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,045	12,736	5,045	38,826	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,307		1,307	12
13	DD 16 OR LESS					13
14	TOTALS	21,045	14,043	5,045	40,133	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.58%

D. How many bed-hold days during this year were paid by Public Aid?
219 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 3/27/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 5,045

Medicare Intermediary AdminaStar Federal - Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Coventry Village # 0033498 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	174,643	18,523	6,403	199,569		199,569		199,569			1
2	Food Purchase		249,513		249,513		249,513	(6,609)	242,904			2
3	Housekeeping	83,732	22,534	1,214	107,480		107,480		107,480			3
4	Laundry	78,200	17,892	1,167	97,259		97,259	(7,677)	89,582			4
5	Heat and Other Utilities			149,731	149,731		149,731		149,731			5
6	Maintenance	46,295	6,420	49,514	102,229		102,229		102,229			6
7	Other (specify):*											7
8	**TOTAL General Services**	382,870	314,882	208,029	905,781		905,781	(14,286)	891,495			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,427,956	48,856	4,628	1,481,440		1,481,440		1,481,440			10
10a	Therapy	28,109	389	220,193	248,691		248,691		248,691			10a
11	Activities	76,825	2,803	1,299	80,927		80,927		80,927			11
12	Social Services	53,018		1,201	54,219		54,219		54,219			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,585,908	52,048	233,321	1,871,277		1,871,277		1,871,277			16
	C. General Administration											
17	Administrative	79,949		294,110	374,059		374,059	105,433	479,492			17
18	Directors Fees											18
19	Professional Services			37,345	37,345		37,345		37,345			19
20	Dues, Fees, Subscriptions & Promotions			6,407	6,407		6,407	(227)	6,180			20
21	Clerical & General Office Expenses	91,290	15,388	36,240	142,918		142,918		142,918			21
22	Employee Benefits & Payroll Taxes			497,199	497,199		497,199		497,199			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,195	4,195		4,195	(938)	3,257			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			216,068	216,068		216,068	(2,406)	213,662			26
27	Other (specify):*											27
28	**TOTAL General Administration**	171,239	15,388	1,091,564	1,278,191		1,278,191	101,862	1,380,053			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,140,017	382,318	1,532,914	4,055,249		4,055,249	87,576	4,142,825			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Coventry Village #0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			166,974	166,974		166,974		166,974			30
31	Amortization of Pre-Op. & Org.			48,092	48,092		48,092		48,092			31
32	Interest			308,971	308,971		308,971	(13,663)	295,308			32
33	Real Estate Taxes			60,540	60,540		60,540		60,540			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,648	11,648		11,648		11,648			35
36	Other (specify):*											36
37	**TOTAL Ownership**			596,225	596,225		596,225	(13,663)	582,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,382	2,853	130,235		130,235		130,235			39
40	Barber and Beauty Shops			17,878	17,878		17,878		17,878			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):*	67,047	4,120	348,868	420,035		420,035	(420,035)				43
44	**TOTAL Special Cost Centers**	67,047	131,502	437,489	636,038		636,038	(420,035)	216,003			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,207,064	513,820	2,566,628	5,287,512		5,287,512	(346,122)	4,941,390			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,609)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(7,677)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,663)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(15,000)	17		17
18	Fines and Penalties				18
19	Entertainment	(938)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance	(2,406)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(227)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(420,035)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (466,555)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	120,433	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 120,433		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (346,122)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Coventry Village

ID# **0033498**

Report Period Beginning: **1/1/03**

Ending: **12/31/03**

	NON-ALLOWABLE EXPENSES	**Amount**	**Sch. V Line Reference**	
1	Cottage Expense	$ (420,035)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(420,035)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Coventry Village # 0033498 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,609)	0	0	0	0	0	0	0	0	0	0	(6,609)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(7,677)	0	0	0	0	0	0	0	0	0	0	(7,677)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,286)	0	0	0	0	0	0	0	0	0	0	(14,286)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	105,433	0	0	0	0	0	0	0	0	0	0	105,433	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(227)	0	0	0	0	0	0	0	0	0	0	(227)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(938)	0	0	0	0	0	0	0	0	0	0	(938)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,406)	0	0	0	0	0	0	0	0	0	0	(2,406)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	101,862	0	0	0	0	0	0	0	0	0	0	101,862	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	87,576	0	0	0	0	0	0	0	0	0	0	87,576	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Coventry Village** **#** **0033498** **Report Period Beginning:** **1/1/03** **Ending:** **12/31/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,663)	0	0	0	0	0	0	0	0	0	0	(13,663)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,663)	0	0	0	0	0	0	0	0	0	0	(13,663)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(420,035)	0	0	0	0	0	0	0	0	0	0	(420,035)	43
44	**TOTAL Special Cost Centers**	(420,035)	0	0	0	0	0	0	0	0	0	0	(420,035)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(346,122)	0	0	0	0	0	0	0	0	0	0	(346,122)	45

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sterling Morris Retirement Associates Ltd. Partnership	100	Walnut Grove Retirement Community	Morris, IL	Harris Webber Ltd.	Northbrook, IL	R.E. Development

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Management Fee	$ 279,110	Harris Webber Ltd.		$ 399,543	$ 120,433	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 279,110			$ 399,543	$ * 120,433	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Harris F. Webber	General Partner	President	Genl Ptnr	156,495	12.5	31.24	Salary	$ 149,233	17,7	1
2	Myra A. Webber	Treasurer	Clerical Support	0.00	6,388	6.25	31.24	Salary	6,092	17,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 155,325		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Harris Webber Ltd.
Street Address: 666 Dundee Road, Suite 930
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847-272-9686
Fax Number: (847-272-0524

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat & Other Utilities	Direct Cost	15,690,690	5	$ 6,745	$	4,867,477	$ 2,092	1
2	6	Maintenance	Direct Cost	15,690,690	5	7,418		4,867,477	2,301	2
3	11	Activities	Direct Cost	15,690,690	5	1,104		4,867,477	342	3
4	17	Administrative	Direct Cost	15,690,690	5	964,604	964,604	4,867,477	299,234	4
5	19	Professional Services	Direct Cost	15,690,690	5	22,677		4,867,477	7,035	5
6	20	Fees, Subscriptions & Promos	Direct Cost	15,690,690	5	4,079		4,867,477	1,265	6
7	21	Clerical & General Office Exp.	Direct Cost	15,690,690	5	32,537		4,867,477	10,093	7
8	22	Employee Benefits & Payroll	Direct Cost	15,690,690	5	111,377		4,867,477	34,551	8
9	24	Travel & Seminar	Direct Cost	15,690,690	5	2,223		4,867,477	690	9
10	26	Insurance - Prop, Liab, Mal	Direct Cost	15,690,690	5	18,319		4,867,477	5,683	10
11	30	Depreciation	Direct Cost	15,690,690	5	31,370		4,867,477	9,731	11
12	32	Interest	Direct Cost	15,690,690	5	1,770		4,867,477	549	12
13	34	Rent-Facility & Grounds	Direct Cost	15,690,690	5	75,499		4,867,477	23,421	13
14	35	Rent-Equipment & Vehicles	Direct Cost	15,690,690	5	8,239		4,867,477	2,556	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,287,962	$ 964,604		$ 399,543	25

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	National City		X	Mortgage		11/07/87	$ 2,781,478	$	Refi	8.7500	$ 30,936	1
2	National City		X	Expansion Loan		08/01/97	2,460,742		Refi	9.0000	42,588	2
3	National City		X	2003 Refi Loan		03/26/03	3,997,299	3,877,099	03/26/08	7.2900	201,261	3
4	Harris Webber	X		Loan				621,252		Prime + 1	33,822	4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 9,239,519	$ 4,498,351			$ 308,608	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 9,239,519	$ 4,498,351			$ 308,608	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Coventry Village # 0033498 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	60,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,000	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,540	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	60,540	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	19,200	8
	1999	17,900	9
	2000	88,525	10
	2001	58,000	11
	2002	60,000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Coventry Village COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0033498

CONTACT PERSON REGARDING THIS REPORT Scott Farnam

TELEPHONE 847-272-9686 x235 FAX #: 847-272-0524

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-151-002	PT W 1/2 NW, Sec 16 TWP 21	$ 105,677.00	$ 60,540.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 105,677.00	$ 60,540.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,746 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	95,000	1987	$ 59,079	1
2	Cottages		1987&1994	237,649	2
3	TOTALS	95,000		$ 296,728	3

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94			1987	$ 2,092,159	$ 52,304	40	$ 52,304	$	$ 771,343	4
5	36			1997	2,264,443	56,611	40	56,611		367,670	5
6				2000	150,000	3,750	40	3,750		13,125	6
7				2003	335,559	442		442		442	7
8											8
	Improvement Type**										
9	Land Improvements			1989	179,998	12,000	15	12,000		176,713	9
10	Land Improvements			1990	4,960	331	15	331		4,464	10
11	Land Improvements			1991	13,522	(251)	15	(251)		12,915	11
12	Land Improvements			1992	895	60	15	60		686	12
13	Land Improvements			1993	3,878	259	15	259		2,714	13
14	Land Improvements			1994	12,806	854	15	854		8,032	14
15	Land Improvements			1995	1,165	78	15	78		660	15
16	Land Improvements			1997	564	38	15	38		245	16
17	Land Improvements			1998	2,011	134	15	134		737	17
18	Land Improvements			2001	3,525	235	15	235		588	18
19	Land Improvements			2003	15,155		15				19
20											20
21											21
22	Building Improvements			1992	5,706	380	15	380		3,502	22
23	Building Improvements			1993	3,541	236	15	236		1,896	23
24	Building Improvements			1994	12,322	821	15	821		6,146	24
25	Building Improvements			1995	33,652	2,243	15	2,243		20,993	25
26	Building Improvements - Heat Pump			1996	3,980	265	15	265		1,990	26
27	Building Improvements - Heat Pump			1997	5,580	372	15	372		2,418	27
28	Building Improvements - Floor Tile			1997	705	71	10	71		459	28
29	Building Improvements - Shower Room			1997	2,227	148	15	148		964	29
30	Building Improvements			1998	41,229	2,749	15	2,749		15,117	30
31	Building Improvements - Flooring			1999	37,788	2,519	15	2,519		11,337	31
32	Building Improvements			2001	5,340	356	15	356		890	32
33	Building Improvements - Dining Room Windows			2002	764	51	15	51		102	33
34	Building Improvements			2003	2,894		15				34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,236,368	$ 137,054		$ 137,054	$	$ 1,426,147	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,142,631	$ 30,145	$ 30,145	$		$ 966,442	71
72	Current Year Purchases	33,774	588	588			588	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,176,404	$ 30,732	$ 30,732	$		$ 967,030	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Van - 1994	1994	$ 48,424	$	$	$	7	$ 48,424	76
77	Patient Transport	Motor for Van	2003	1,998	143	143		7	143	77
78										78
79										79
80	TOTALS			$ 50,422	$ 143	$ 143	$		$ 48,567	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,759,923	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 167,930	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,930	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,441,744	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottages	$ 6,413,375	$ 160,334	$ 1,296,209	86
87	Cottages-Improvements	162,550	10,076	51,623	87
88	Cottages-FFE	138,082	181	101,606	88
89	Cottages-Land Improvements	431,332	28,480	227,703	89
90					90
91	TOTALS	$ 7,145,339	$ 199,071	$ 1,677,141	91

G. Construction-in-Progress

	Description	Cost	
92	CIP-Apartments	$ 302	92
93	CIP-Cottages	2,109	93
94	CIP-Cottage Expansion	85,168	94
95		$ 87,579	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$ 0	1,724	$ 75,244		$	1,724	$ 75,244	1
2	Licensed Speech and Language Development Therapist		hrs	0	579	25,265			579	25,265	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		61 hrs	1,061	2,741	119,683			2,802	120,744	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$ 1,061	5,044	$ 220,192		$	5,105	$ 221,253	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Coventry Village **#** 0033498 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 427,487	$	1
2	Cash-Patient Deposits	7,013		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 72,909)	498,419		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,797		6
7	Other Prepaid Expenses	2,903		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,037,619	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	296,728		13
14	Buildings, at Historical Cost	12,243,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,364,908		16
17	Accumulated Depreciation (book methods)	(4,117,737)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	87,579		22
23	Other(specify):	46,004		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,921,108	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,958,727	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 278,875	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,463		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,746		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,797		32
33	Accrued Interest Payable	12,562		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	1,547,596		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,096,039	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,877,099		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Cottage Deferred Income	6,118,172		43
44	Entrance Fee Liability	524,367		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,519,638	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,615,677	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,656,951)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,958,726	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,582,306)	1	
2	Restatements (describe):		2	
3	**Beg. Bal diff**	25,257	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,557,049)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(99,902)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (99,902)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,656,951)	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,907,731	1
2	Discounts and Allowances for all Levels	(885,818)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,021,913	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	461,155	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 461,155	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,348	13
14	Non-Patient Meals	6,609	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	148,573	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	988	19
20	Radiology and X-Ray		20
21	Other Medical Services	484	21
22	Laundry	20,338	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 199,340	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,663	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,663	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cottages	491,539	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 491,539	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,187,610	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	905,781	31
32	Health Care	1,871,277	32
33	General Administration	1,278,191	33
	B. Capital Expense		
34	Ownership	596,225	34
	C. Ancillary Expense		
35	Special Cost Centers	568,148	35
36	Provider Participation Fee	67,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,287,512	40
41	**Income before Income Taxes (line 30 minus line 40)****	(99,902)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (99,902)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Coventry Village # 0033498 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,640	1,805	$ 46,051	$ 25.51	1
2	Assistant Director of Nursing	320	320	7,101	22.19	2
3	Registered Nurses	14,885	15,510	313,569	20.22	3
4	Licensed Practical Nurses	17,876	18,956	319,125	16.84	4
5	Nurse Aides & Orderlies	71,196	76,530	740,496	9.68	5
6	Nurse Aide Trainees	265	265	1,615	6.09	6
7	Licensed Therapist	61	123	1,061	8.63	7
8	Rehab/Therapy Aides	1,966	2,212	27,048	12.23	8
9	Activity Director	1,521	1,664	24,573	14.77	9
10	Activity Assistants	5,986	6,520	52,252	8.01	10
11	Social Service Workers	3,463	3,793	53,018	13.98	11
12	Dietician					12
13	Food Service Supervisor	1,865	2,096	29,546	14.10	13
14	Head Cook	5,441	5,950	51,089	8.59	14
15	Cook Helpers/Assistants	13,766	14,636	94,007	6.42	15
16	Dishwashers					16
17	Maintenance Workers	3,896	4,265	46,295	10.85	17
18	Housekeepers	11,173	12,051	84,565	7.02	18
19	Laundry	9,414	9,876	78,201	7.92	19
20	Administrator	2,080	2,080	79,949	38.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,640	7,212	91,290	12.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Cottages	6,200	6,760	67,047	9.92	33
34	TOTAL (lines 1 - 33)	179,654	192,624	$ 2,207,898 *	$ 11.46	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,403		35
36	Medical Director		6,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400		39
40	Physical Therapy Consultant	2,741	119,683		40
41	Occupational Therapy Consultant	1,724	75,244		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	579	25,266		43
44	Activity Consultant		1,299		44
45	Social Service Consultant		1,201		45
46	Other(specify) Barber/Beauty		17,878		46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,044	$ 255,374		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joan Elliott	Administrator	n/a	$ 79,949
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,949

B. Administrative - Other

Description	Amount
Harris Webber Mgmt Services	$ 279,110
Harris F. Webber	7,500
Harris F. Webber	7,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 294,110
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wildman Harold HW LTD	Legal	$ 434
Ward, Murray, Pace & Johnson	Legal	5,101
Much Schelist Freed Denenberg	Legal	2,570
Crowe Chizek & Company	Accounting	24,615
Medi.com	Accounting	635
ADP	Payroll Services	9,719
Advanced Answers on Demand	Computer	5,527
IVANS	Computer	3,177
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,778

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 159,359
Unemployment Compensation Insurance	
FICA Taxes	180,138
Employee Health Insurance	106,872
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	16,144
Life Insurance	3,226
Other Employee Benefits	15,943
TOTAL (agree to Schedule V, line 22, col.8)	$ 481,682

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,600
Advertising: Employee Recruitment	1,817
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscriptions	32
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,449

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Nursing related travel	2,953
Seminar Expense	383
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,336

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Repair Pipes	1994	$ 1,982	7	$ 283	$ 142	$ 0	$ 0	$	$	$	$	$
2	Heating & Cooling	1994	9,110	7	1,301	651	0	0					
3	Interior Maint	1994	1,092	7	156	78	0	0					
4	Heating & Cooling	1995	2,638	5	528	0	0	0					
5	Interior Maint	1995	1,376	5	275	0	0	0					
6	Make-up Air System	1996	1,452	5	290	50	0	0					
7	No 1997 Additions												
8	No 1998 Additions												
9	No 1999 Additions												
10	No 2000 Additions												
11	No 2001 Additions												
12	No 2002 Additions												
13	No 2003 Additions												
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,650		$ 2,833	$ 921	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,997** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,890**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Crowe Chizek and Co. LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.